

Lowry Pediatrics

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

Medical Records From:

Lowry Pediatrics
8101 E. Lowry Blvd, Suit 260
Denver, Co 80230
Phone Number: 720-859-8222
Fax Number: 720-859-9777

Sending Medical Records To:

Patient Name _____ Birth Date _____ SSN _____

Address _____ Telephone _____

I AM REQUESTING RECORDS TO BE SENT TO: _____
*Name Of New Office

Phone _____ Fax _____ Email _____
*REQUIRED *REQUIRED*

Address _____

Purpose of Request _____

Please disclose the following information (please circle):

Entire Medical Record	Immunization Record
Physicians Notes	Daycare Forms
Lab Results/ X-Ray Reports	Sports Forms
Behavioral Health	Camp Forms
Return to Work Authorization	Other: _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavior or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on _____ (Max. 6 months)

Signature of Patient or Guardian _____ Date _____

Relationship to Patient _____